

Application for Use of MH/DD/SAS Trust Funds for Enhancement of Contracted Provider Child Mental Health Services Continuum: SFY 05

Intensive In-Home Services (from 10-15-04 final draft of new and revised service definitions)¹

Service Definition and Required Components

This is a time-limited intensive family preservation intervention intended to stabilize the living arrangement, promote reunification or prevent the utilization of out-of-home therapeutic resources (i.e., psychiatric hospital, therapeutic foster care, residential treatment facility) for the identified youth through the age of 20. These services are delivered primarily to children in their family's home with a family focus to:

1. Diffuse the current crisis, evaluate its nature, and intervene to reduce the likelihood of a recurrence;
2. Ensure linkage to needed community services and resources;
3. Provide self-help and living skills training for youth;
4. Provide parenting skills training to help the family build skills for coping with the youth's disorder;
5. Monitor and manage the presenting psychiatric and/or addiction symptoms; and
6. Work with caregivers in the implementation of home-based behavioral supports. Services may include crisis management, intensive case management, individual and/or family therapy, substance abuse intervention; skills training, and other rehabilitative supports to prevent the need for an out-of-home, more restrictive services.

This intervention uses a team approach designed to address the identified needs of children and adolescents who are transitioning from out of home placements or are at risk of out-of-home placement and need intensive interventions to remain stable in the community. This population has access to a variety of interventions twenty-four (24) hours a day, seven (7) days per week by staff that will maintain contact and intervene as one (1) organizational unit.

Team services are individually designed for each family, in full partnership with the family, to minimize intrusion, and maximize independence. Services are generally more intensive at the beginning of treatment and decrease over time as the youth and family's coping skills develop. The team services are structured and delivered face-to-face to provide support and guidance in all areas of functional domains: adaptive, communication, psychosocial, problem-solving, behavior management, etc. This service is **not** delivered in a group setting.

A service order for Intensive In-Home services must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Respite Services (from current – under revision document)

Community Respite – CMSED: This service is provided to youths' families or custodians who need periodic relief from the constant and often stressful care of the youth. Respite/short-term residential services may be provided in either a planned or an emergency basis. While in respite/short-term residential care, a youth receives care that addresses the health, nutrition and daily living needs of the child. Respite/short-term residential services may be provided according to a variety of models. These may include, weekend care, emergency care, or continuous care up to 30 days. This service is to support the youth and the family in their residential placement. This service may be provided in a variety of locations, including homes or facilities, according to licensure requirements noted under Provider requirements. This is a 24-hour service. This service is not Medicaid billable.

Hourly Respite – CMSED: This service is to give youths' families or custodians periodic short term relief from the constant and often stressful care of the youth. Respite/hourly services may be provided in either a planned or an emergency basis. The respite provider provides care that addresses the health, nutrition and daily living needs of the child. Hourly respite may be used up to eight hours. When more than 8 hours is used for Respite, the entire service must be billed to Community Respite. This service is to support the youth and the family in their residential placement. This service may be provided in a variety of locations, including homes or facilities, according to licensure requirements noted under Provider Requirements.

¹ Check the Division's public website regularly for definition updates.

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Crisis Services and Standards

(excerpted from Division's 11/24/04 draft Policy Guidance Development of Community-Based Crisis Stabilization Services)

Crisis services shall be designed for prevention, intervention and resolution, not merely triage and transfer,...

Currently, every person receiving enhanced services must have a crisis plan. The Community Support team who developed the crisis plan with the person is also responsible for monitoring (usually twice a month) and updating the crisis plan. The crisis plan includes identifying the first responder in any crisis event. While Community Support can be used for crisis response as medically necessary, it is the primary provider who knows the client best. Therefore, it is the primary provider who is responsible for first response to the crisis event.

Service definitions and standards that are in review by the North Carolina Division of Medical Assistance (DMA) and the federal Centers for Medicaid and Medicare Services (CMS) are used here to identify those that are applicable to the provision of crisis services. See the most current version of the definitions for accuracy and additional entrance criteria and service limitations.

Tables 1 and 2 present examples of relevant child and youth-related crisis services definitions according to responsibility by first responders or by LME. This is not an exhaustive list.

Table 1. Examples of "First Response" to crisis using proposed service definitions²

Service	Description	Location
Community Support-Children/Adolescents (MH/SA)	Face to face with the client.	Any location (such as home, school or homeless shelter).
Intensive In-Home Services	Time-limited intensive family preservation intervention intended to diffuse the current crisis, evaluate its nature, and intervene to reduce the likelihood of a recurrence. Ultimately to stabilize the living arrangement, promote reunification or prevent the utilization of out-of-home therapeutic resources (i.e., psychiatric hospital, therapeutic foster care, and residential treatment facility).	Primarily delivered in the child and family's home.
Multisystemic Therapy (MST)	A program designed to enhance the skills of youth who have antisocial, aggressive/violent behaviors, are at risk of out-of-home placement due to delinquency; are adjudicated youth returning from out-of-home placement; are chronic or violent juvenile offenders, and/or are youth with serious emotional disturbances involved in the juvenile justice system.	Any location.
Targeted Case Management for Individuals with Developmental Disabilities	A service to assist individuals in gaining access to and monitoring needed services and supports through development of person-centered plan and crisis plan.	Any location.
Substance Abuse Intensive Outpatient Program (SAIOP)	Structured individual and group addiction activities and services provided for recovery and recovery maintenance.	An outpatient program.

² First response may be provided by services not shown here.

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The LME is responsible for making crisis intervention services available for new clients, for established clients without a primary provider who provides first response, and for recipient clients when the capacity of the first responder has been exceeded. The following are service definitions of services that an LME may encourage when building community capacity.

Table 2. Other crisis service definitions for building community capacity

Service	Description	Location
Mobile Crisis Management (MH/SA)	Support, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions, and crisis prevention activities available 24/7/365.	Face-to-face with the consumer and in locations outside the agency's facility in the least restrictive environment and in or close to a person's home, school, work, local emergency room, etc.
Inpatient Hospital Psychiatric Treatment (MH/SA)	An organized, licensed 24-hour service that provides intensive evaluation and treatment delivered in an acute care inpatient setting by medical and nursing professionals under the supervision of a psychiatrist. This service is designed to provide continuous treatment for individuals with acute psychiatric problems.	Community hospital psychiatric unit. Also applies to use of the regional state psychiatric hospital through bed day allocation.
Facility based Crisis Intervention	An alternative to hospitalization in a 24-hour residential facility that provides support and crisis services in a community setting. Can be provided in a non-hospital setting for recipients in crisis who need short term intensive evaluation, treatment intervention or behavioral management to stabilize acute or crisis situations.	A licensed facility 10 NCAC 14V.5000.

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EXAMPLE OF A BEST PRACTICE MODEL FOR IN-HOME INTENSIVE SERVICES¹

Brief History

Appalachian Family Innovations (AFI) began as Bringing It All Back Home (BIABH) in 1973. The Bringing It All Back Home “Project” was initially operated in affiliation with the NC Division of Mental Health out of offices on the Western Carolina Center campus in Morganton, NC. The Project was originally funded by the Appalachian Regional Commission and the Law Enforcement Assistance Administration. Its purpose was to bring a new technology of group home treatment, then called the Achievement Place Program, from Kansas University where it was developed to western North Carolina. Eight [group homes](#) for adolescents with behavioral/emotional problems were established around the region, and operating those programs using the new treatment program was BIABH’s only business.

In 1979, administrative responsibility for each of these group homes was transferred from BIABH to local Boards of Directors which had become non-profit corporations and the care-providers, called Teaching-Parents, became employees of the Boards. Concurrently, BIABH changed its administrative affiliation from the Division of Mental Health to Appalachian State University and moved to a new office location in downtown Morganton. Also in 1979, BIABH became one of the original three Sponsor Sites certified by the newly founded Teaching-Family Association, along with Father Flanagan’s Boys Town and the Achievement Place Research Project. At that time, 17 group homes had contracts with BIABH — now called the BIABH Study Center — for its training and support services. BIABH was still exclusively in the group home business, but that was soon to change.

Study Center staff had for some time begun to see a need for alternative placements and treatment strategies for the increasing numbers of children being referred for services. Beginning in late 1979, BIABH began to experiment with new treatment/placement programs. That year, the [Professional Parenting](#) program was begun with National Institute of Mental Health (NIMH) funding to provide quality foster care for special needs children.

That program was an instant success and immediately began to expand. And, in 1985, BIABH made its first venture into the world of family preservation services with its [Home Remedies](#) program which has also greatly expanded since then. There was also a pressing need for high quality supported adoption programs; BIABH answered that need in 1992 with its [Adoption Plus \(A+\)](#) program which is now offered state-wide. Since then, all of those programs have expanded, new ones have been added, and both the Study Centers’ budget and staff have increased substantially.

In 2003, Bringing It All Back Home changed its name to **Appalachian Family Innovations**. Our new name captures the region of the country we serve, demonstrates our strong relationship with Appalachian State University, reflects our primary commitment to families, and points to our leadership in developing novel and effective programs from children and families.

Current Configuration

In addition to the programs mentioned above, BIABH added two programs in the mid 90’s. Offered by Professional Parenting, these programs were aimed at the special needs of children and adolescents with sexual behavior problems. The first, for younger clients, is our **Intensive Program**, and the second, **Sexual Abuse Intervention Services**, is for adolescent sexual offenders and their families.

Our newest program, begun in 2000, is offered by Home Remedies. **Catawba Valley Healthy Families**, a voluntary primary prevention program, affords intensive in-home services to overburdened families of newborns through the child’s third birthday. All the while, interest and need has grown for good quality group home treatment, and Appalachian Family Innovations presently contracts with ten agencies in and beyond North Carolina providing

¹ Please note that the Division is not requiring that Area/County Programs propose to implement this particular best practice in-home intensive services model. This is included only as an example to get Area/County Programs started in their research of best or emerging practice in intensive in-home services.

Teaching-Family support services to 41 group homes and campus based cottages. In addition to these programs of care and intervention, AFI has ventured, successfully, out of our kids homes and into their schools with our *The Missing Curriculum: Teaching Social Competencies in the Classroom* teacher training program. That program is available to public schools throughout the state. Each of these programs is described in detail elsewhere on this site. Together, these programs and activities form a net of youth and family care and treatment that is as effective, significantly less restrictive, and measurably more cost effective than any alternatives now available to the children, families, and schools we serve. Appalachian Family Innovations now operates out of several offices from Winston-Salem to Asheville, with a combined staff of 60, and a budget in FYI 2001 of \$4.75 million dollars.

Abstracts:

Evidence-Based Practice in Child and Adolescent Mental Health Services

Kimberly Hoagwood, Ph.D., Barbara J. Burns, Ph.D.,
Laurel Kiser, Ph.D., Heather Ringeisen, Ph.D. and
Sonja K. Schoenwald, Ph.D.

The authors review the status, strength, and quality of evidence-based practice in child and adolescent mental health services. The definitional criteria that have been applied to the evidence base differ considerably across treatments, and these definitions circumscribe the range, depth, and extensionality of the evidence. The authors describe major dimensions that differentiate evidence-based practices for children from those for adults and summarize the status of the scientific literature on a range of service practices. The readiness of the child and adolescent evidence base for large-scale dissemination should be viewed with healthy skepticism until studies of the fit between empirically based treatments and the context of service delivery have been undertaken. Acceleration of the pace at which evidence-based practices can be more readily disseminated will require new models of development of clinical services that consider the practice setting in which the service is ultimately to be delivered.

Hoagwood K., **The policy context for child and adolescent mental health services: implications for systems reform and basic science development.** Ann, NY Acad Sci. 2003 Dec;1008:140-8.

New York State Office of Mental Health, Columbia University, 1078 Riverside Drive #78, New York, NY 10031, USA. hoagwood@childpsych.columbia.edu

Significant state and national policy initiatives are focusing on strategies for financing and structuring the delivery of evidence-based services for children. These initiatives reflect, in part, an increased awareness of and respect for scientific standards about effective treatments and services. At the same time, major studies of system reform and organizational behavior are calling into question the effectiveness of current practices and identifying the complexities of taking science-based services to scale. Four major policy initiatives are described and the implications of scientific developments within the basic neurosciences for improving policy, practice, and service in children's mental health is discussed.

PMID: 14998880 [PubMed - indexed for MEDLINE]

Brown, A.W., **The state of mental health services for children and adolescents: an examination of programs, practices and policies.** J Health Soc Policy. 2002;16(1-2):139-53.

Howard University, School of Social Work, USA.

This article presents an overview of the state of mental health services for children and adolescents. It provides a brief historical review of policies affecting mental health services for children and adolescents with emotional and behavioral disorders. It discusses the roles of various systems in the provision services for emotionally and

behaviorally disordered children and adolescents, and the need for cross-systems collaboration and funding. A model psycho-educational day treatment program. City Lights, is highlighted as an approach to serving inner-city African American adolescents with a profile of services and of the types of youth best served by such a program. PMID: 12809384 [PubMed - indexed for MEDLINE]

Evidence Based Practices Related to Children & Youth

<http://psychservices.psychiatryonline.org/cgi/content/full/52/9/1179>

Article in Psychiatric Services, September 2001, Hoagwood et al., "Evidence-Based Practice in Child and Adolescent Mental Health Services."

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Link&db=PubMed&dbFrom=PubMed&from_uid=11533391

search results of articles in PubMed related to EBP and children/adolescents = 621 articles

<http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf>

Chapter 5 of President's New Freedom Commission Report regarding

- Evidence based practices for children: multisystemic therapy (MST), treatment foster care (ADA therapeutic foster care), and parent child interactive therapy.
- Emerging best practices are school mental health, systems of care and wraparound.

www.omh.state.ny.us/omhweb/ebp/children.htm

New York evidence based practices: functional family therapy (FFT)

www.nri-inc.org/CMHQA/CMHQA.cfm

National Association of State Mental Health Program Director's Research Institute (NRI), Center for Mental Health Quality and Accountability
Evidence based practices for youth

SAMHSA – creating toolkits on EBP for children's services in next few years

www.colorado.edu/cspv/blueprints/matrix/criteria.html

databases cataloging the evidence about children's services

<http://gucchd.georgetown.edu/datamatters6.pdf>

journal issue on evidence-based practices and children's services

www.oup.com/us/catalog/general/subject/?view=usa&ci=0195134575#productdetails

Book by Barbara Burns & Kimberly Hoagwood,

Community Treatment for Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders (2002)

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Kirk, Raymond S. and Griffith, Diane P., "Annual Report to the General Assembly of the State of NC on the Intensive Family Preservation Services Program for the 2002-2003 State Fiscal Year," January 2004.

Kirk, Raymond S. and Griffith, Diane P., "Intensive Family Preservation Services: Demonstrating Placement Prevention Using Event History Analysis," Social Work Research, 28(1), March 2004, pp. 5-18.

Appalachian Family Innovations (was Bringing it All Back Home)
www.familyinnovations.org

<http://www1.dshs.wa.gov/basicneeds/an2fss.html>

Washington State Department of Social and Health Services on Intensive Family Preservation Services (IFPS)

<http://www.servalt.com/family.html>

Service Alternatives for Washington, Inc. discusses Family Preservation Services

Organizations and Web Sites

American Bar Association (ABA) Center on Children and the Law
www.abanet.org/child

American Humane Association (AHA)
www.americanhumane.org

Casey Family Programs
www.casey.org

The Center for Law and Social Policy (CLASP)
www.clasp.org

Chapin Hall Center for Children
www.chapin.uchicago.edu

Children's Defense Fund (CDF)
www.childrensdefense.org

Children's Rights
www.childrensrights.org

Child Trends
www.childtrends.org

Child Welfare League of America (CWLA)
www.cwla.org

Kids Count
www.aecf.org/kidscount

National Adoption Information Clearinghouse (NAIC)
www.calib.com/naic

National Association of Foster Care Reviewers (NAFCR)
www.nafcr.org

National Black Child Development Institute (NBCDI)
www.nbcdi.org

National Center for Youth Law
www.youthlaw.org

National Conference of State Legislatures
www.ncsl.org

National Council of Juvenile and Family Court Judges
<http://ncjfcj.unr.edu>

National Court-Appointed Special Advocate Association
www.nationalcasa.org

National Family Preservation Network (NFPN)
www.nfpn.org

National American Council on Adoptable Children (NACAC)
www.nacac.org

Prevent Child Abuse America
www.preventchildabuse.org

Urban Institute
www.urban.org

U.S. Dept. of HHS Administration for Children and Families
www.acf.dhhs.gov

The Future of Children
www.futureofchildren.org